GEORGIA STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS
237 Coliseum Drive, Macon, Georgia 31217-3858
(478) 207-2440 (Telephone) * www.sos.ga.gov/plb/psych

PRE-DOCTORAL INTERNSHIP DOCUMENTATION
FORM A
(REQUIRED OF ALL APPLICANTS)

INSTRUCTIONS

- This form is to be completed by the Applicant.
- It is to be signed by the Applicant and the Training Director.

NAME OF APPLICANT:

DOCTORAL PROGRAM:

DATE DOCTORAL DEGREE GRANTED:

INTERNSHIP

PRIMARY INTERNSHIP SITE: _____

- **If more than one site will be used, indicate this separately in "Settings/Rotations" section below.**

INTERNSHIP PERIOD: BEGAN _____ COMPLETED _____
Month/Year Month/Year

WAS THIS INTERNSHIP APA-ACCREDITED 0R APPIC MEMBER DURING THIS PERIOD? ❒ Yes ❒ No

TRAINING DIRECTOR - LICENSED PSYCHOLOGIST

- **Identify the licensed psychologist responsible for overall supervision of your total Internship.**

AGENCY:_____

TRAINING DIRECTOR OF INTERNSHIP:_____

TITLE: _____ ACADEMIC DEGREE:_____SPECIALITY:_____
LICENSE #: _____ STATE:_____ YEAR ISSUED: _____ EXPIRATION: _____
MAILING ADDRESS:_____
Street

_____
City State Zip Code
TELEPHONE: ( ) _____ FAX: ( ) _____ E-MAIL: _____
ABPP DIPLOMA: YEAR_____ SPECIALIZATION _____
MEMBER OF AMERICAN PSYCHOLOGICAL ASSOCIATION? ❒ Yes ❒ No

-

SETTING/ROTATION #1	SETTING/ROTATION #2	SETTING/ROTATION #3
Site:	Site:	Site:
Dates: From To	Dates: From To	Dates: From To
Total Hours:	Total Hours:	Total Hours:
Supervisor:	Supervisor:	Supervisor:
License #:	License #:	License #:
State:	State:	State:
# Years Licensed:	# Years Licensed:	# Years Licensed:
Specialty Area:	Specialty Area:	Specialty Area:

TOTAL HOURS OF CREDITED INTERNSHIP EXPERIENCE:

EVIDENCE OF INTERNSHIP SITE SATISFYING REQUIRED CRITERIA

DESCRIBE THE PLANNED, PROGRAMMED SEQUENCE OF TRAINING EXPERIENCES PROVIDED IN THE INTERNSHIP_____

_____

_____

_____

_____

SUPERVISING PSYCHOLOGISTS

- Identify by title and position the licensed or other psychologist(s) involved in supervision at each agency/setting included in the Internship.

Supervisor Name:_____
Title: _____
Position: _____

❒ Yes ❒ No Did this supervisor co-sign reports, and insurance claims? If "No," please explain._____
_____
_____

❒ Yes ❒ No Was this supervisor on site (N/A for I/O) and available?

❒ Yes ❒ No Was this supervisor related to you in any manner? If "Yes," please explain. _____
_____

Supervisor Name:_____
Title: _____ _____
Position: _____

❒ Yes ❒ No Did this supervisor co-sign reports, and insurance claims? If "No," please explain. _____
_____
_____

❒ Yes ❒ No Was this supervisor on site (N/A for I/O) and available?

❒ Yes ❒ No Was this supervisor related to you in any manner? If "Yes," please explain._____
_____

Supervisor Name:_____
Title: _____
Position: _____

❒ Yes ❒ No Did this supervisor co-sign reports, and insurance claims? If "No," please explain._____
_____
_____

❒ Yes ❒ No Was this supervisor on site(N/A for I/O) and available?

❒ Yes ❒ No Was this supervisor related to you in any manner? If "Yes," please explain. _____
_____

Supervisor Name: _____
Title: _____
Position: _____

❒ Yes ❒ No Did this supervisor co-sign reports, and insurance claims? If "No," please explain. _____
_____
_____

❒ Yes ❒ No Was this supervisor on site (N/A for I/O) and available?

❒ Yes ❒ No Was this supervisor related to you in any manner? If "Yes," please explain._____
_____

- Was at least 80% of your supervision provided by licensed psychologist(s)? ( ) Yes ( ) No
- Did your supervisor carry professional responsibility for your cases? ( ) Yes ( ) No
- Was the internship completed in no less than 11 months and no more than 24 months after its inception (48 months for I/O)? ( ) Yes ( ) No
- Did your internship consist of at least 2000 hours of organized training experiences appropriate to your academic program specialty area? ( ) Yes ( ) No
- Did you spend at least 500 hours in direct contact with clients/patients? ( ) Yes ( ) No

RANGE OF DIRECT PATIENT ASSESSMENT AND TREATMENT ACTIVITIES IN THE INTERNSHIP EXPERIENCE

Describe briefly:

Were you requested to maintain a file on each patient? ❒ Yes ❒ No **If "No," please explain.**

Average number of hours per week of formal face-to-face, individual supervision of your cases: _____	Average number of hours per week of group supervision [case conference/seminar/co-therapy]: _____
Total number of semester hours of pre-internship graduate coursework completed: _____	Number of Interns in training at this site when you were there: _____
Was a written Internship Agreement signed before the inception of the Internship? ❒ Yes ❒ No If "No," please explain:_____ _____ _____	Title used to designate and identify trainee to clients during the Internship: ❒ Intern ❒ Resident ❒ Fellow ❒ Other _____

Are any copies available of any brochures, announcements, or statements prepared by the agency to describe goals and content of the Internship available? ❒ Yes ❒ No

INTERNSHIP HOURS

TOTAL HOURS OF INTERNSHIP EXPERIENCE:_____
Total Number of Hours of **Direct Client Contact**:_____
Total Number of Hours of **Supervision, Training, & Education**:_____
Total Number of Hours in **Research Activities**:_____

SIGNATURES

APPLICANT

_____ _____
Date Signature of Applicant

TRAINING DIRECTOR

I certify that the conditions outlined in this statement are an accurate description of the Internship Experience provided in the named agency or agencies.

_____ _____
Date Signature of Training Director

GEORGIA STATE BOARD OF EXAMINERS OF PSYCHOLOGISTS
237 Coliseum Drive Macon, Georgia 31217-3
(478) 207-2440 * www.sos.ga.gov/plb/psych

TO BE FILLED OUT BY THE TRAINING DIRECTOR: Please put in sealed envelope, with your **signature written across the envelope flap** and either return to the applicant or forward under separate cover to the Board of Examiners.

INSTRUCTIONS:

This Applicant is seeking to become a licensed practitioner of Psychology in Georgia. In effect, the Applicant is claiming the readiness for independent professional practice without direct supervision.

Please give the Board your assessment of the Applicant's level of preparation for independent practice at the end of their internship year. The Board understands that the Applicant is required to attain a year of Supervised Work Experience following the completion of the doctoral degree.

Please add specific recommendations relating to the Applicant's additional needs for professional development.

Use this SCALE:

Level 1 - Ready for independent practice
Level 2 - Needed continued supervision
Level 3 - Had not achieved minimal competence (unsatisfactory)
N/A - I can make no judgment relative to this area

Name of Applicant_____

■

READINESS IN TERMS OF THEORETICAL KNOWLEDGE AND SKILLS **(CIRCLE ONE)** 1 2 3 N/A
READINESS IN TERMS OF APPLIED KNOWLEDGE AND SKILLS **(CIRCLE ONE)** 1 2 3 N/A
READINESS IN TERMS OF PERSONAL FUNCTIONING **(CIRCLE ONE)** 1 2 3 N/A
READINESS IN TERMS OF ETHICAL PRACTICE **(CIRCLE ONE)** 1 2 3 N/A

Please describe any specific recommendations you may have had relating to the Applicant's additional needs for professional development.

SIGNATURE OF TRAINING DIRECTOR:

_____ _____

Signature of Training Director Date